DEPARTMENT OF CORRECTIONS
AGENCY OF HUMAN SERVICES
STATE OF VERMONT

NUMBER

_____ POLICY

_____ DIRECTIVE

_____ PROCEDURE

361.01.01 PROTOCOL

SUBJECT	EFFECTIVE DATE	REVIEWED AND RE-ISSUED	SUPERSEDES
Mental Health Receiving Screening	8/20/97		NEW

RECOMMENDED FOR APPROVAL BY:	AUTHORIZED BY:
SIGNATURE	SIGNATURE

I. AUTHORITY

28 V.S.A. Section 801; 28 V.S.A. Section 903; 28 V.S.A. Section 906; 28 V.S.A. Section 907.

II. PURPOSE

Inmates will be screened upon arrival to identify urgent mental health and medical needs requiring immediate evaluation and treatment. Early identification of inmates with serious mental illness or in need of medical or mental health services requires an expedited referral to the appropriate clinical staff for further evaluation, crisis services, psychological consultation, special housing and or a full mental health evaluation.

III. APPLICABILITY/ACCESSIBILITY

All individuals and groups affected by the operations of the Department of Corrections may have a copy of this procedure.

IV. DEFINITIONS

Mental Health Professional: means a person with professional training, experience and demonstrated competence in the treatment of mental illness, who is a physician, psychiatrist, psychologist, social worker, nurse, psychiatric nurse practitioner or other qualified person determined by the Commissioner of Developmental and Mental Health Services.

Initial Needs Survey (INS): is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population, and to identify those newly admitted inmates in need of medical care.

Serious Mental Illness: means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

V. PROCEDURE

Inmates entering DOC facilities will receive health and mental health screening by health, mental health and/or correctional and booking staff immediately upon arrival as part of the booking process.

A. The mental health screening process will include administration of the *Initial Needs Survey* (INS). This screening shall consist of inquiry regarding the following:
   1. Does the transporting officer believe the inmate may be a suicide risk;
   2. Presence or absence of sources of support;
   3. Recent experience(s) of significant loss;
   4. Presence of serious problems causing significant distress and worry;
   5. Past history of suicidal behavior of a family member or significant other;
   6. History of mental illness and/or hospitalization;
   7. History of drug/alcohol problems;
   8. Suicidal ideation and/or past suicidal behavior;
   9. Current presence of drugs in the body which were not prescribed by a doctor;
   10. Observations of inmate (incoherence, crying, anxiety, statements/ indicators of suicide risk).

B. The facility admission process will include administration of the *Intake Medical Screening* form in accordance with Directive 315.01 (Intake and Bail).

C. Disposition
   1. The disposition for the INS shall be determined according to the Scoring and Action Sheet on the back of the INS.
      a. If the Total Score exceeds the designated cutoff, or if one of the (*) items is marked, the Shift Supervisor must be notified and any action must be documented in the appropriate section of the Scoring and Action Sheet.
      b. In the event that an inmate refuses to respond to three or more items or any one (*) item on the INS or is otherwise unable to do so, the Shift Supervisor shall be notified automatically.
      c. If notified by the Screening Officer, the Shift Supervisor must complete the designated section of the Scoring and Action Sheet (supervision or observation instituted and documentation of those notified).
      d. All notified parties must follow-up with the inmate and document their actions in the inmate's medical chart.

   2. The disposition and any action taken (whether an immediate referral to an advanced clinical provider or mental health professional, transport to an outside medical facility or routine processing) will be documented in the inmate's medical chart.

3. A progress note will be included in the medical record indicating
   a. date and time of arrival;
   b. transferring facility;
   c. other pertinent clinical information not included on the screening form.

D. All completed INS forms shall be placed in the designated space in the booking office where they will be collected by mental health staff.

E. All inmates who are returning from a criminal court proceeding in which they were a party, whose furlough/release status has been revoked, or who are otherwise readmitted to the facility will also be administered the INS in order to identify and prevent potential harm to self or others.

F. All completed INS forms will be logged on the *Initial Needs Survey Log* form prior to their being filed in the medical record. All log forms shall be forwarded to Central Office for compilation of statistics.

VI. REFERENCES

28 V.S.A. Section 801; 28 V.S.A. Section 903; 28 V.S.A. Section 906; 28 V.S.A. Section 907.

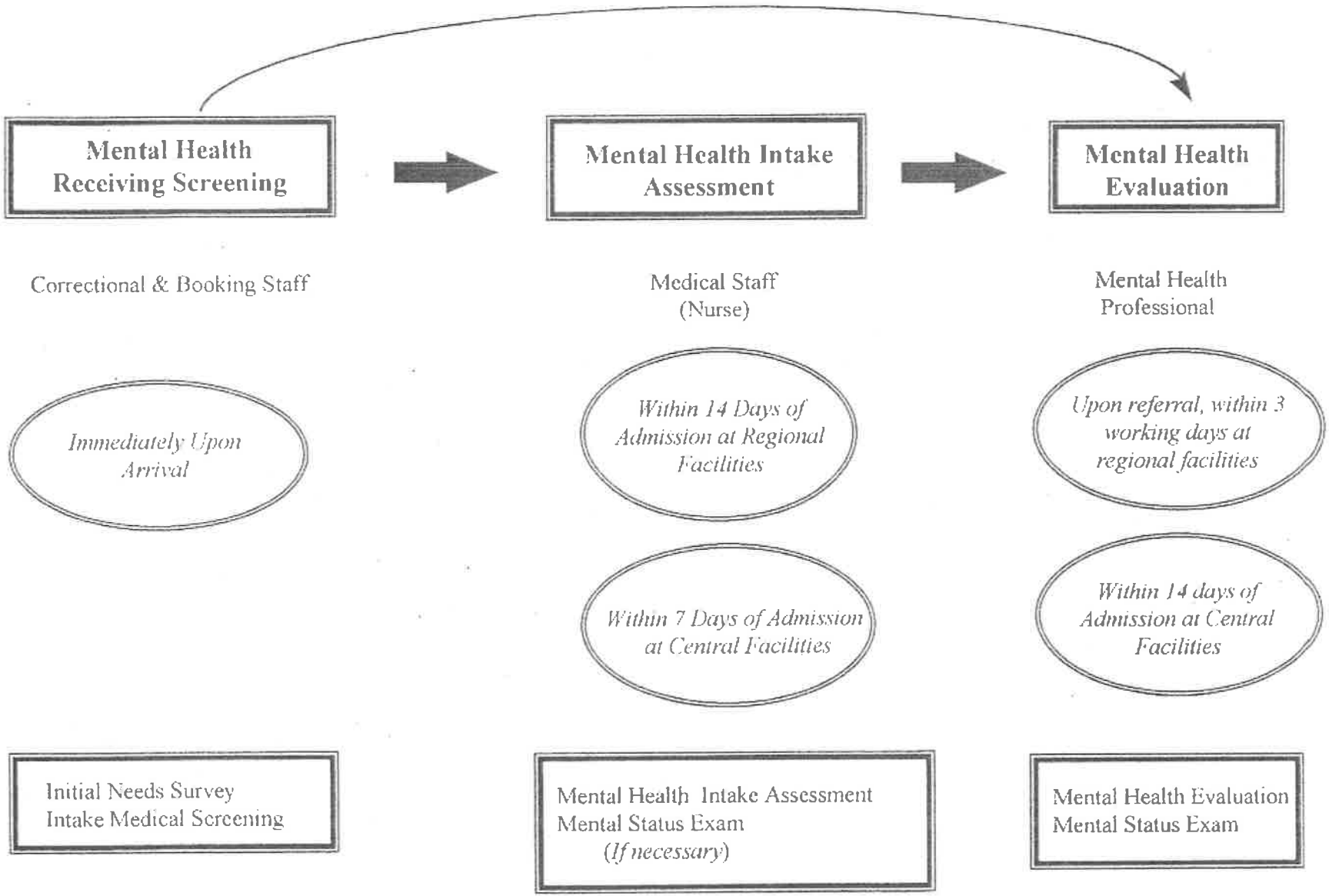
NCCHC Adult Standards 1992 P-54
NCCHC Adult Standards 1996 J-51

ACA 1990 3-4343, 3-4344

VII. DRAFT PARTICIPANTS

This directive was drafted by Thomas Powell, Ph.D., Clinical Director, 103 S. Main St., Waterbury, VT 05671. Also actively participating in development of this directive were Erin Turbitt, Sandy Dengler, Shirley Meier, R.N., M.Ed., and Chris Carr, Ph.D.

PROGRESSION OF MENTAL HEALTH SERVICES



INITIAL NEEDS SURVEY

Inmate Name: _____ Facility: _____

Date: _____ Time: _____ Screening Officer: _____ _____

Print Signature

Directions on Reverse Side

	Yes	No	*
1. Does the transporting officer believe the inmate may be a suicide risk?			*
2. "_____, is this your first arrest?"			
3. "Is there anyone who would visit you while you are held at this facility, post bail for you, or accept a collect call from you?"			
4. "Have you lost your job in the last six months?"			
"Has your marriage or relationship broken up in the last six months?"			
"Has a close friend or relative died in the last six months?"			
5. "Do you have any serious money problems?"			
"Do you have any serious problems with your spouse, girl/boyfriend or members of your family?"			
"Do you or anyone close to you have serious medical problems?"			
"Do you fear losing your job?"			
6. "Has anyone in your family or anyone close to you ever committed suicide?"			*
7. "Have you ever been admitted to a Mental Hospital?"			
"Are you taking any medication for your nerves which was prescribed to you by a doctor?"			
"Have you been to a Mental Health Agency or a private counselor in the last six months?"			
8. "Have you ever gotten a DWI or DUI?"			
"Have you ever received treatment or counseling for drug or alcohol problems?"			
"Have drugs or alcohol ever caused problems for you such as losing your job, or fights with girl/boyfriend or spouse?"			
"Has anyone ever been upset by or complained about your alcohol or drug use?"			
9. "Do you have any thoughts about hurting or killing yourself?"			*
10. "Have you ever attempted to take your own life?"			*
11. "Do you feel there is anything to look forward to?"			*
12. "Do you have any drugs in your system that were not prescribed by a doctor?"			
13. Is the inmate incoherent, showing signs of substance abuse, chemical withdrawal or mental illness?			*
14. Does the inmate hold a position of respect in the community or is the charge shocking in nature (e.g., rape of a child)?			*
15. Individual shows signs of depression (e.g., crying, "defeated" posture, blank or zombie-like look or repeated sighing)			
16. Inmate appears overly anxious, afraid or is raging (e.g., hand wringing, profuse sweating, panting, excessive fidgeting or pacing)			
17. Inmate appears to feel unusually embarrassed or ashamed (e.g., statements like "I'll never be able to face boss/family again")			
18. Inmate is behaving in a strange manner (e.g., not making sense, hearing, seeing, or smelling things that aren't there, disorientation or extreme withdrawal)			*
TOTALS			

SCORING AND ACTION SHEET

Screening Officer Action

1. For item #1, ask the transporting officer the question listed.
   For items #2 through #12, ask the inmate the questions listed.
   For items #13 through #18, record your observations.

2. For those items containing multiple questions, a single "Yes" response results in a check in the "Yes" box (note the diagonal lines blocking out the extra Yes/No boxes on these items). If the inmate does not respond "Yes" to any of the questions in these items, place a check in the "No" box.

3. Add the total number of check marks in the shaded boxes. Enter this figure below. If the total number is 8 or more, contact the Shift Supervisor.

   TOTAL SCORE: _____

4. If you checked any of the shaded boxes for which the (*) column contained a *, notify the Shift Supervisor. These are critical items for which immediate attention is warranted.

   Was the Shift Supervisor notified? ☐ YES ☐ NO

Upon completion of this form, if there is no indication to contact the Shift Supervisor, please place this form in the designated space in the Booking Office.

Shift Supervisor Action

If you are notified by the Screening Officer, complete the following:

1. Supervision or Observation Instituted

   ☐ None ☐ 10 Minute Checks ☐ Constant ☐ Other (explain) _____

2. Others Notified

   ☐ Superintendent: _____
   ☐ Assistant Superintendent: _____
   ☐ Casework Supervisor: _____
   ☐ Facility Nurse/Medical: _____
   ☐ Mental Health Professional: _____

Shift Supervisor: _____ _____ Date: _____ Time: _____
Name *Signature*

Upon completion of this form, please place it in the designated space in the Booking Office.

INITIAL NEEDS SURVEY LOG FORM

Inmate Name	Date Form Completed	Total Score	Any Hot Item Scored (yes/no)	Shift Supervisor Notified (yes/no)	Placed on Watch (yes/no)	MH Staff Notified (yes/no)

When this form is completed, please forward a copy to Central Office.

DOC/CO/PRO/361.01.01-B
Rev. 8/97

INTAKE MEDICAL SCREENING

Inmate Name: _____ DOB: _____
Facility: _____ Date: _____

Anticipated Period of Commitment	
☐ Over 30 Days ☐ 30 Days or Less ☐ Interrupt ☐ Weekend ☐ Unknown	☐ New Admission ☐ Interdepartment Transfer

Ask each newly admitted inmate the following questions:	Yes	No
1. Are you allergic to any medications?		
If "Yes," which ones?		
2. Are you allergic to any foods or additives?		
If "Yes," what are they?		
3. Are you currently taking, or are supposed to be taking any medications?		
If "Yes," fill out form entitled *Pre-existing Medication*.		
4. Are you currently on a diet which has been ordered by a physician for medical reasons?		
5. Do you have any current dental problems?		
6. Do you have any current or past medical problems that we should be aware of?		
If "Yes," what are they?		

Do you have any of the following?

☐ Diabetes ☐ Asthma ☐ Heart Trouble ☐ Seizures/Epilepsy ☐ Hepatitis ☐ T.B.
☐ High Blood Pressure ☐ Mental Illness ☐ Body Lice or Crabs ☐ AIDS ☐ Venereal Disease

	Yes	No
7. Have you used alcohol during the past 24 hours?		
If "Yes," Number of drinks: _____ How long ago: _____		
8. Have you used drugs within the last 3 days?		
If "Yes," Which drugs: _____ How long ago: _____ How: _____		
9. Do you have any problems which occur after stopping the use of drugs or alcohol?		
If "Yes," Please explain: _____		

Note the following by observation (notify supervisor of any positive items)

☐ Tearful or crying ☐ Jaundiced or yellow skin ☐ Pale ☐ Nervous ☐ Obvious
☐ Artificial limb(s) ☐ Limp or problem walking ☐ Slurred Speech ☐ Sweating Sores Bleeding
☐ Sweating ☐ Shaking or tremors ☐ Flushed Rashes Cuts
☐ Depressed ☐ Confusion of thought Needle marks

Comments: _____

Intake Officer's Signature: _____ Date: _____ Time: _____

Supervisor's Signature: _____ Date: _____ Time: _____

PRE-EXISTING MEDICATION

The following medication was brought with the inmate or is reported by the inmate as having been prescribed for his/her use:

Description	Dosage	Original Count/Volume	Current Contents *(Bottle Full, 3/4 Full, ½ Full, or 1/4 Full)*

Prescribing Physician: _____

Physician's Address: _____ Phone #: _____

Have inmate read and sign if medication accompanied them to the facility.

I understand that, while I am incarcerated, it is the sole responsibility of the Vermont Department of Corrections medical personnel and providers to prescribe medication. This may result in a discontinuation or change in my prescription.

Inmate's Signature: _____
Date of Admission: _____ Time: _____
Witness: _____

Officer's Signature: _____
Date: _____ Time: _____

This section is to be completed by medical personnel.

The above described medication(s) was received by _____
Print Name

and verified/not verified on _____ by _____.
Date Print Name

_____ _____
Medical Staff Signature Date